Critical Incident Report

COMPLETE ONLY ONE SETTING/PROGRAM SECTION
ALL AREAS OF CONSUMER STATUS MUST BE COMPLETE

Indiana Family and Social Services Administration
Division of Mental Health and Addiction
402 West Washington Street W353
Indianapolis, IN 46204
Fax: 317-233-1986

Legal Name of Reporting Agency:

Location/Address of Incident (Number, Street, City, State, ZIP Code):

Date of Incident*: (mm/dd/yyyy)*_____ **Time of Incident: _____ am _____ pm**

Residential Setting Type:
440 IAC 7.5 *Report is required within 24 hours of incident. Check only **one** setting.*

- ☐ **1**. Transitional Residential **(TRS)**
- ☐ **2.** Semi Independent Living **(SILP)**
- ☐ **3**. Alternative Family for Adults **(AFA)**
- ☐ **4**. Sub Acute Stabilization (**Sub Acute)**
- ☐ **5.** Supervised Group Living **(SGL)**
- ☐ **6.** Agency owned building /structure **(Agency Apt.)**
- ☐ **7.** Other *(Specify)* _____

Type of Residential Incident: *Check only **one** incident type.*

- ☐ **1.** Fire
- ☐ **2.** Injury
- ☐ **3**. Suicide attempt
- ☐ **4.** Emergency room visit
- ☐ **5**. Elopement
- ☐ **6.** Police response
- ☐ **7.** Alleged exploitation, abuse, or neglect
- ☐ **8.** Suicide
- ☐ **9.** Death
- ☐ **10**. Assault
- ☐ **11**.Other (*Specify*) _____

Outpatient/Community Based Setting Type:
*Report is required within 72 hours of incident. Check only **one** setting.*

- ☐ **1**. Office
- ☐ **2.** Consumer's residence (apartment, house, etc.)
- ☐ **3.** Foster care home
- ☐ **4**. Other (*Specify*) _____

Type of Outpatient/Community Based Incident:
*Check only **one** incident type.*

- ☐ **1**. Serious Bodily Injury
- ☐ **2**. Suicide attempt
- ☐ **3.** Suicide
- ☐ **4.** Death
- ☐ **5.** Homicide
- ☐ **6**. Other (S*pecify)* _____

Other Agency Related Incidents:
*Report is required within 72 hours of incident. Check only **one** box.*

- ☐ **1**. Staff death on property
- ☐ **2.** Visitor death on property
- ☐ **3.** Staff serious bodily injury on property
- ☐ **4.** Visitor serious bodily injury on property
- ☐ **5.** Public health concern (*Specify*) _____
- ☐ **6**. High profile community event involving agency (*Specify*) _____
- ☐ **7.** Breach of Confidentiality (*Specify*) _____
- ☐ **8**. Event causing facility or site closure (*Specify*) _____
- ☐ **9**. Event causing the relocation of consumers (*Specify*) _____
- ☐ **10.** Other major consumer or employee incident (*Specify*) _____

Private Mental Health Institution: 440 IAC 1.5 *Incidents 1-5 require a verbal report within 24 hours of incident and a written report within ten (10) working days. Check only **one** incident type.*

- ☐ **1**. Death of consumer not related to seclusion or restraints.
- ☐ **2.** Death while consumer was in restraint or seclusion; within 24 hours after being removed from restraint or seclusion; within one (1) week after restraint or seclusion where it is reasonable to assume that the use of restraint or placement in seclusion contributed directly or indirectly to that consumer's death ("reasonable to assume" includes, but is not limited to, death related to: (A) restrictions of movement for prolonged periods of time; (B) chest compression; (C) restriction of breathing; or (D) asphyxiation.).
- ☐ **3.** A serious, unexpected consumer injury resulting in or potentially resulting in loss of function and/or marked deterioration in a consumer's condition.
- ☐ **4**. Chemical poisoning resulting in actual or potential harm to the consumer.
- ☐ **5**. Disruption of Service exceeding four (4) hours caused by internal disasters, external disasters, strikes by health care workers, or unscheduled revocation of vital services.
- ☐ **6.** Consumer missing or cannot be located for more than 24 hours
- ☐ **7**. Kidnapping of consumer
- ☐ **8**. Admission of child (14 & under) to an adult unit
- ☐ **9.** Documented violation of rights
- ☐ **10**. Unexplained loss or theft of a controlled substance
- ☐ **11.** Fire/ Explosion with emergency response
- ☐ **12**. Other *(Specify)* _____

Consumer or Alleged Victim Name:	**Sex:** ☐ **Male** ☐ **Female**	**Age:**	☐ 1.Consumer ☐ 2.Staff/Volunteer ☐ 3.Guardian/Caregiver ☐ 4. Other (*Specify)* _____	Multiple Consumers or Alleged Victims ☐ Yes ☐ No
Alleged Perpetrator Name:	**Sex:** ☐ **Male** ☐ **Female**	**Age:**	☐ 1.Consumer ☐ 2.Staff/Volunteer ☐ 3.Guardian/Caregiver ☐ 4. Other (*Specify)* _____	Multiple Alleged Perpetrators ☐ Yes ☐ No

Critical Incident Report

Endangered Adult or Child Notification Made to:

Adult Protection Services (APS) **Child Protective Services (CPS)** **If yes, indicate the date notified:** ***(mm/dd/yyyy)***

☐ **Yes** ☐ **No** ☐ **N/A** ☐ **Yes** ☐ **No** ☐ **N/A** **Date:** _____

Consumer/Alleged Victim Status: *Complete all fields. Each item requires a response. If a field does not apply, enter N/A. If unknown, enter Unknown.*

1. Date last seen for service(s) *(mm/dd/yyyyy)*:_____
2. Pending Legal Charges Related to this Incident: □ Yes □ No Type: _____
3. Precautions Prior to Incident *(Specify)* : _____
4. Precautions Initiated After Incident *(Specify)*: _____
5. Significant medical history (*primary medical condition*): _____
6. Medications: _____
7. Medication Changes in the Last 90 Days: □ Yes □ No Specify: _____
8. Services received (*check all that apply*)

☐ Individual therapy ☐ ACT ☐ N/A

☐ Group therapy ☐ Detoxification Inpatient /Outpatient

☐ Medication Management ☐ AMHH Services

☐ Case Management ☐ BPHC ☐ Other *(Specify)*: _____

Description of Events/Incident:

Incident Resolution and/or Agency Plan of Action:

Will an internal review of this incident be conducted by the agency? ☐ **Yes** ☐ **No**

Name of Person Completing Form: _____ **Date: (***mm/dd/yyyy)* _____

Name of Agency Contact for DMHA Follow-Up: _____ **Telephone Number:** ( )

DMHA Only

Agency Number: _____ **Incident ID Number:** _____

Date Incident Received From Provider: _____ **Date Forwarded to Liaison/Staff:** _____

Report Submitted by Agency Within Required Time Parameters: ☐ Yes ☐ No

Date Follow-Up Initiated: *(mm/dd/yyyy)* _____ **Date of Report Closure:** *(mm/dd/yyyy)* _____

Date Referred to Cert/Lic: *(mm/dd/yyyy or N/A)*_____ **Liaison/Staff Initials:** _____

DMHA Only

Medical Review Notations:

Additional Review Required: □ Yes □ No

Signature of Medical Director: _____ **Date: (***mm/dd/yyyy)* _____